Town of Brookline
Health Reimbursement Arrangement (HRA) Voucher
JULY 1, 2017 TO JUNE 30, 2018

CPA, INC.
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Braintree, MA 02184

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(781) 848-8477 (Fax)
(781) 848-9848 (Phone)

EMPLOYEE: _____ **SS#:** _XXX_ -_XX_ - _____

ADDRESS: _____**CITY:**_____

STATE: _____ **ZIP:** _____**PHONE: ( )**_____**E-MAIL:** _____

NAME OF MEMBER INCURRING THE CLAIM: _____

Reimbursement for subscriber and family members enrolled in
Non-Medicare group health plans through the GIC/Town of Brookline.
ALL EXPENSES MUST BE INCURRED BETWEEN JULY 1, 2017 THROUGH JUNE 30, 2018.

Type of Medical Care COPAY Expenses	**Co-pay charged**	**Reimbursable Amount**	**Date of Service/ Bill Date**	**Total Reimbursement**
Example: *ER co-pay*	*$100.00*	*$50.00*	*7/25/17*	*$50*
Out-patient Day Surgery		$150.00		
Inpatient Hospital Admission		$500.00		
Emergency Room		$50.00		
High-Tech Imaging		$100.00		

TOTAL CLAIM AMOUNT: $_____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's co-payment Reimbursement Arrangement. I have not been reimbursed from any other source including insurance programs or other programs offered by my employer. None of these expenses have previously been submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed as deductions for income tax purposes. I hereby request reimbursement for these claims.

All medical claims submitted require copies of original invoices, receipts or claim summaries from your insurance company. Eligible co-payment for reimbursement include: up to $150 for out-patient day surgery co-pays, up to $500.00 for inpatient hospital admission co-pays, $50.00 for Emergency Room co-pays and $100.00 for High-Tech imaging co-pays (MRI, CT scan, PET scan) for members requiring three or more high-tech imaging services that result directly from a serious and/or chronic medical condition. Reimbursements will be on the 3rd high-tech imaging co-pay.

PARTICIPANT'S SIGNATURE: _____ **DATE**: _____